

DIVISION OF DEVELOPMENTAL DISABILITIES
PLAN OF CARE MEETING SURVEY

TO BE COMPLETED BY DDD STAFF		
POC MEETING DATE		
WAIVER: <input type="checkbox"/> Basic <input type="checkbox"/> Core <input type="checkbox"/> Basic Plus <input type="checkbox"/> Community Protection		

This survey is voluntary and confidential. Your services will not be affected by your choice to participate or not to participate. This survey will help us improve the Plan of Care process.

What is your relationship to the person receiving services?

☐ I am the person receiving services. ☐ Family Member/Guardian ☐ Paid Staff ☐ Friend/Advocate

SURVEY				
NO.	QUESTION	(1) YES	(2) NOT SURE	(3) NO
1.	During the plan of care process, was your Case Manager respectful and courteous?			
2.	Did your Case Manager ask if you had any concerns about your current services?			
3.	Were your concerns discussed and included in the planning process?			
4.	Did you help develop your new Plan of Care?			
5.	Did you receive information about what services are available in your waiver to meet your assessed needs?			
6.	Were you given a choice of services that are available in your waiver to meet your assessed needs?			
7.	Were you given a choice of service providers?			
8.	Did you plan to meet your needs and goals for both waiver and non-waiver services?			
9.	Were your health and safety needs discussed?			
10.	Were plans made to meet your health and safety needs?			
11.	Did you plan for emergencies, such as an earthquake or if your regular provider is unavailable?			
12.	Did you receive information on what to do if your needs change before the next annual planning meeting?			
13.	Did you receive information on how to make a complaint or ask for a fair hearing?			
14.	Please use the space below to provide additional comments; or to tell us what suggestions you have to improve the Plan of Care process.			

DSHS 15-295 (12/2004) - TRANSLATED

Please return using the enclosed stamped, addressed envelope, or mail to:

Department of Social and Health Services
Division of Developmental Disabilities (DDD)
Attention: Quality Assurance
PO Box 45310
Olympia WA 98504-5310